Benny's Blog

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Pearl of the Month:

What is Osler's maneuver?

In elderly patients with stiff ("pipestem") arteries the blood pressure may be falsely elevated because of the noncompressibility of the brachial artery. Osler's maneuver, although controversial, is to raise the cuff pressure to eliminate the radial pulse and slowly deflate the cuff to determine at what pressure the pulse returns. Dramatic differences in BP may be seen, and should be considered in treatment decisions.

Warning: The Medicare Auditors are Back Revisiting the Two Midnight Rule

by Ben Hourani, MD, MBA

After a respite from CMS audits for verification of inpatient (IP) status it appears that shortly the Recovery Audit Contactors (RAC) and Medicare Audit Contractors (MAC) will once again ramp up to audit Medicare admissions for all hospitals. This renewed effort in hospital audits coincides with the intent of CMS to set up reviews of physician reimbursement for professional coding. CMS will institute payment reductions to doctors based on quality and cost profiles of individual physicians beginning in 2016.

If the Medicare auditors deem that the patient did not meet IP status they will then retract the original payment made to the hospital. There is a well-defined appeal process, but in the interim the money is reimbursed from Sharp to CMS (minus a percentage fee paid to the RAC auditors). The appeal process can take up to months or even years before a final determination is made favorably or unfavorably for the hospital. Obviously, it behooves us all to document as specifically and completely as possible in our patient care notes to substantiate the need for IP status. Thus, a review and update of the requirements the auditors are looking to justify IP status is indicated and timely.

In October 2013 CMS passed what is commonly referred to as the "Two Midnight Rule" (2MR) which is the cornerstone for IP status when a Medicare patient is admitted to the hospital. There are basically two elements required to be documented to justify IP status. The first is relatively straight forward consisting of an order stating *Admit to inpatient, attending Dr. Smith, the diagnosis, and of course the location* (location does not influence patient status of IP or observation). Although controversial initially and related to admission privileges of emergency doctors, Medicare has clarified the issue and accepted that an ED doc if he/she is familiar with the case and customarily writes the admission order that this meets the requirements of a certified admission order for IP status with the elements listed above. Ideally, the attending or admitting physician should input his/her own admission order in Cerner for IP status if in agreement so no question as to the validity of the IP order exists.

The second requirement for IP status is more open to subjective interpretation and clinical reasoning. The physician must also state the there is a "reasonable clinical expectation" that the patient will require a stay that will equal or surpass two midnights. It is important to state the duration of at least a two midnight stay, but by far more importantly is WHY the physician expects that the patient will require at least two midnights in the hospital. Most audits with outcomes resulting in a take back of payments thus far have been based on disagreement with the clinical reasoning of the physician that the stay will surpass two midnights. Stated otherwise, both diagnostic and therapeutic plans should be completely documented in the admitting note supporting the reasoning for an expected two midnight stay.

The following three examples of clinical reasoning that a Medicare auditor would most likely find agreement with for IP status are examples only (mine), but are helpful to understand the documentation and rea-

Upcoming Events and News of Note:

Sharp HospiceCare BonitaView Home

South Bay hospice care is now a reality. It is with great pleasure that Sharp Chula Vista announces the completion of the Sharp HospiceCare BonitaView Home. The South Bay will now have a beautiful residence for residential hospice care. BonitaView will provide compassionate, end-of-life care, in a warm, home-like setting for our patients in need of hospice care. Special thanks go to Sharp Chula Vista board member, Scott McMillan, and the Corky McMillan Companies for making this dream a reality. The Sharp Chula Vista Auxiliary also deserves special thanks for their contribution.

Grand Rounds, March 25

Dr. Ben Hourani, Physician Advisor, and Dr. Hugo Barrera, Chief of Staff, invite all physicians and health care professionals to a CME/CEU presentation on March 25 at 12:30 p.m. in the Nellie Barrington Room. Dr. Kristopher Downing, staff orthopedist with a specialty fellowship in upper extremity orthopedics, will speak on "Shoulder Arthroplasty, Why and Why Not? Who? When?" Lunch will be served.

Warning: The Medicare Auditors are Back

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soning required.

1. "Mr. Jones has acute on chronic CHF with an elevated creatinine suggestive of Cardiorenal syndrome. He is at high risk of life threatening complications. He will need cautious diuresis with most likely nephrology and cardiology consultation for management and possible ultrafiltration to avoid further decrement in renal function. Electrolyte abnormalities may occur and require careful monitoring. A minimum two midnight stay is expected."

2. "Mrs. Smith has severe pancreatitis with abdominal pain of 8/10 only diminished to 5/10 with MS as well as hypotension. Aggressive fluid resuscitation will be required with careful monitoring of hemodynamic status. If fluid resuscitation is unsuccessful she may require vasopressors and ICU level of care. Work up for etiology of pancreatitis will begin with US of gall bladder and possible CT pending response of patient. Surgical consultation will be requested for help with management and should surgical intervention be required in the event a common duct stone is discovered. Pt is seriously ill and will require at least two midnights in the hospital and probably more."

3. "Pt has fever and an elevated white count. Presentation is strongly suggestive of sepsis and will most likely require ID consult, and empiric antibiotics for now pending ID opinion. Work up for source of infection started. Cultures have been obtained and results will take 48 hours for documentation of source of infection and ID of organism. Monitoring of hemodynamics and attention to electrolytes and urine output indicated to avoid hemodynamic compromise and renal injury. A minimum two day hospital stay will be required and much longer if blood cultures are returned positive."

As these examples suggest, you should input at least the presumptive diagnosis(s), the seriousness, the risks to the patient, and what work up will be required to diagnose, and treat the patient to justify the duration of at least two midnights. Further, doctors are not clairvoyant and rarely a patient unexpectedly improves and may be discharged prior to being in the hospital two midnights. The physician then should document the nature and details of the unexpected recovery in the progress note or DC summary.

Conversely, at times it is unclear on admission whether a patient meets IP status. When in doubt initially, the patient should be placed in "outpatient under observation" status. If after the first midnight the patient does not improve or worsens and discharge cannot be safely effected then the patient can be CONVERTED to IP status where the stay will surpass two midnights. Time begins when therapy is initiated in the ED. It is VERY IMPORTANT to document the medical reasoning for the conversion to IP, and it must be for clinical reasons, not social convenience such as nobody can pick the patient up today. Clearly state the medical reasons for the inability to discharge the observation patient after the first day with comments such as "mild CHF is worsening with more SOB, and orthopnea " or "abdominal pain of unclear etiology is worsening-urgent GI or surgical consult required."

Again, the above scenarios and comments made are meant to suggest the type of verbiage the auditors are looking for and hopefully agree with the physician that there was an appropriate, justified, and reasonable clinical expectation of at least a two midnight stay in support of inpatient status.

Thought for the Day:
"Instead of spending so much time finding yourself, be yourself."- Unknown

Cerner Corner

By Bob Brown, Physician Education IT Specialist

Cerner Concierge

Our next scheduled offering of the Cerner Concierge is April 8, in the Physician Lounge, from 1130—1330. Lunch will be provided and you can stop in and get help with orders, progress notes, or any other Cerner problems that you might have. If you have suggestions or needs, please stop in. Dragon training is available, if scheduled in advance.

Computer Log-On

I have recently received a few calls concerning staff logging into Cerner, just to find that they are under somebody else's access. To combat this, here are a few steps to consider:

- When leaving a computer, remember to log off. Anybody sitting down after you will have full access to your account and can write orders or document in your name.
- Conversely, when approaching a computer, make sure that you log into the computer and see your name at the top of the Cerner screen.

- If you are doing all of these things and still find that you are not the provider, after signing in, please contact your local Clinical Informatics Specialist or the HelpDesk at 858-627-5202 for further troubleshooting.

Stroke PowerPlans Update

Based upon revised Stroke Prevention Guidelines, the **Stroke Ischemic Thrombolysis**, the **Stroke Ischemic Post tPA Admission to ICU**, and the **Stroke Ischemic / TIA Admission** PowerPlans have been updated to better align with new guideline parameters.

Sulfonylurea and Insulin Medication Safety Alerts Effective 3/17/15

Simultaneous use of sulfonylurea medications and insulins significantly increases the risk of hypoglycemia. Two Medication Safety Alerts have been created in Cerner to notify the ordering provider of this risk when placing orders for these medications.

Alert 1:
If patient has an active order for any type of insulin and a provider adds an order for any type of sulfonylurea, an actionable alert will display and will prompt you to either remove or keep the Sulfonylurea order.

Alert 2:
If patient has an active order for any type of sulfonylurea and a provider adds an order for any type of insulin, this alert will display current Active Orders and ask you to consider the discontinuation of the sulfonylurea medication.

ProSolv CVIS Upgrade

ProSolv Cardiovascular Information System (CVIS) was upgraded to a new version to align with ICD10 enterprise initiatives, bringing ProSolv (CVIS) into compliance. This upgrade provides the following:

Improved system performance and stability
Internet Explorer 11 compatibility Framework for advanced reporting

Dragon v2.3 Upgrade

Dragon was upgraded, with a Go-Live date of March 10. This upgrade was done to improve Cerner Dynamic Documentation integration. With this upgrade, some of the improvements include correcting:

Jumping cursor
vSync communication (double lettering)

Anybody wishing to use the Dragon dictation system, please contact your local Clinical Informatics Specialist to schedule a date for training.

New Notes

We are currently creating a new Brief Op-Note which included the necessary items that are required by the Joint Commission. We are also working on a new Interval H&P that will incorporate an assessment section.

Cerner Downtime

Our next scheduled Cerner Downtime is April 18 from 00-04

CPOE statistics for February 2015

Row Labels	WRITTEN	CPOE	TOTAL	%CPOE
SGR Behavioral	8	1687	1695	100%
Sharp Coronado	362	23868	24230	99%
Sharp Grossmont	4086	278400	282486	99%
Sharp Memorial	6480	193450	199930	97%
Sharp Chula Vista	1670	135673	137343	99%
Sharp Mary Birch	3497	75691	79188	96%
Sharp Mesa Vista	5	8777	8782	100%
Grand Total	16108	717546	733654	98%